RESOURCE FOR WRITING THERAPEUTIC NURSING PLANS

40 EXAMPLES OF NURSING PROBLEMS AND INTERVENTIONS

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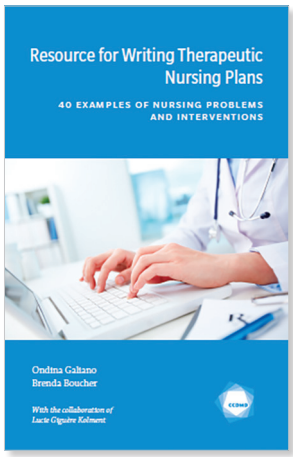
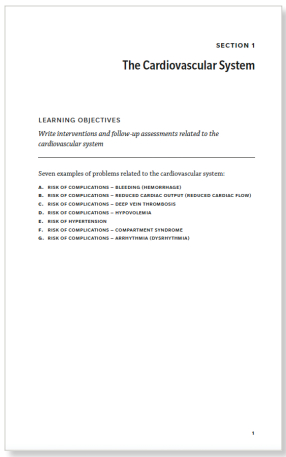



SECTION 1

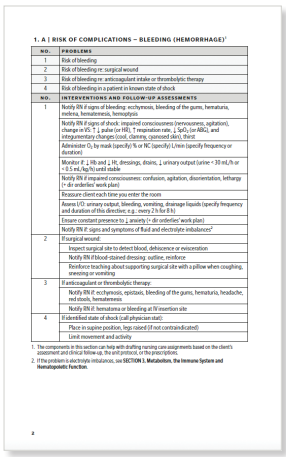
The Cardiovascular System

LEARNING OBJECTIVES

Write interventions and follow-up assessments related to the cardiovascular system

Seven examples of problems related to the cardiovascular system:

A. RISK OF COMPLICATIONS – BLEEDING (HEMORRHAGE)
B. RISK OF COMPLICATIONS – REDUCED CARDIAC OUTPUT (REDUCED CARDIAC FLOW)
C. RISK OF COMPLICATIONS – DEEP VEIN THROMBOSIS
D. RISK OF COMPLICATIONS – HYPOVOLEMIA
E. RISK OF HYPERTENSION
F. RISK OF COMPLICATIONS – COMPARTMENT SYNDROME
G. RISK OF COMPLICATIONS – ARRHYTHMIA (DYSRHYTHMIA)


1. A | RISK OF COMPLICATIONS – BLEEDING (HEMORRHAGE)[1]

NO.	PROBLEMS
1	Risk of bleeding
2	Risk of bleeding re: surgical wound
3	Risk of bleeding re: anticoagulant intake or thrombolytic therapy
4	Risk of bleeding in a patient in known state of shock
NO.	**INTERVENTIONS AND FOLLOW-UP ASSESSMENTS**
1	Notify RN if signs of bleeding: ecchymosis, bleeding of the gums, hematuria, melena, hematemesis, hemoptysis
	Notify RN if signs of shock: impaired consciousness (nervousness, agitation), change in VS: ↑ ↓ pulse (or HR), ↑ respiration rate, ↓ SpO_2 (or ABG), and integumentary changes (cool, clammy, cyanosed skin), thirst
	Administer O_2 by mask (specify) % or NC (specify) L/min (specify frequency or duration)
	Monitor if: ↓ Hb and ↓ Ht; dressings, drains; ↓ urinary output (urine < 30 mL/h or < 0.5 mL/kg/h) until stable
	Notify RN if impaired consciousness: confusion, agitation, disorientation, lethargy (→ dir orderlies' work plan)
	Reassure client each time you enter the room
	Assess I/O: urinary output, bleeding, vomiting, drainage liquids (specify frequency and duration of this directive; e.g., every 2 h for 8 h)
	Ensure constant presence to ↓ anxiety (→ dir orderlies' work plan)
	Notify RN if: signs and symptoms of fluid and electrolyte imbalances[2]
2	If surgical wound:
	Inspect surgical site to detect blood, dehiscence or evisceration
	Notify RN if blood-stained dressing: outline, reinforce
	Reinforce teaching about supporting surgical site with a pillow when coughing, sneezing or vomiting
3	If anticoagulant or thrombolytic therapy:
	Notify RN if: ecchymosis, epistaxis; bleeding of the gums, hematuria, headache; red stools, hematemesis
	Notify RN if: hematoma or bleeding at IV insertion site
4	If identified state of shock (call physician stat):
	Place in supine position, legs raised (if not contraindicated)
	Limit movement and activity

1. The components in this section can help with drafting nursing care assignments based on the client's assessment and clinical follow-up, the unit protocol, or the prescriptions.
2. If the problem is electrolyte imbalances, see **SECTION 3, Metabolism, the Immune System and Hematopoietic Function.**

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Description

This book provides tools to facilitate the task of writing problems, nursing interventions, and follow-up assessments, which can prove demanding and complex. It:

- groups problems by system,
- uses biological and pathophysiological knowledge to describe the problems, the nursing interventions, and the follow-up assessments,
- promotes cooperation between members of the care team to optimize their contribution to clinical follow-up, and
- offers a variety of interventions and follow-up assessments.

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